How to Apply for Long Term Disability (LTD) Benefits with Great-West Life

If your absence on sick leave is prolonged, and if you do have LTD coverage, it will be necessary for you to submit an application for LTD benefits at least 6 weeks before your sick leave runs out.

For information about your sick leave entitlement, please consult your collective agreement or your employee booklet. You may also want to speak to your manager or your union representative.

1. Review the enclosed **Employee Statement Guide** and complete the:

   - **Employee Statement including banking information.**
   - **Your consent form with your signature** which allows the City to release relevant medical information from your City of Ottawa Employee Health and Wellness file and personal information required on the **Employer Statement.** It also permits information exchange between Great-West Life and the City of Ottawa for purposes of rehabilitation and return-to-work planning. Send these completed forms to Great-West Life to get your application for LTD started.

2. Have your physician complete the **Attending Physician's Statement** including your illness category as shown in the black oval circle at the **top right side of the form.** If your illness does not fall under one of the specific categories, use the one marked "**Other Conditions"**. To avoid delays, ask your physician to include the clinical notes, test results, and if available, consult reports from specialists that were obtained during the illness for which you are applying for LTD benefits.

3. Fax, mail or email all completed documents to Great-West Life:
   - Fax to 1 844 569-3133

   - Email a scanned copy of the completed and signed form to ottawa.dmso@greatwestlife.com
     Note: sending your form by email is not a secure medium at this time.

   - Mail to: The Great-West Life Assurance Company
     Disability Management Services Office
     Suite 302
     1600 Scott Street
     Ottawa ON K1Y 4N7

4. Keep a copy of all documents for your reference.

5. Once this information is received by Great-West Life, a case manager will contact you to discuss your claim.

6. Should you have any questions pertaining to your disability claim, please call the Great-West Life - Disability Management Services Office at 613 761-3940 / 1 800 283-5375.

OMERS Disability Waiver of Contributions enables you to earn credited service, if approved, without making pension contributions during a period of disability. The OMERS WAIVER application will be sent to you within the next six months directly from OMERS. You must submit a copy of the Great-West Life **Attending Physician's Statement** to apply for an OMERS waiver. If you have any questions about this benefit, please call Pension & Benefits at 613 580-2424 ext 47411.

Facts about LTD Benefits:

LTD benefits are administered by Great-West Life on behalf of the City of Ottawa. Once your claim is approved:

- ✓ LTD benefits are paid once a month, on the last working day of the month.
- ✓ Your monthly benefit is based on 75% of your salary on your last day of work (67% for Para Transpo employees).

- ✓ If your LTD claim is approved, you will not be required to pay the following: OMERS contributions (if waiver approved), union dues, CPP (QPP), EI, health, dental and basic life benefit premiums. The City will cover these expenses on your behalf.
- ✓ Your LTD benefit may be reduced if you receive paid disability/sick leave benefits from other sources such as Canada Pension Plan, Workplace Safety and Insurance Board (WSIB), Employment Insurance, City of Ottawa etc.
- ✓ As per your group contract, a seventeen (17) week waiting period of disability (illness) is required prior to being eligible for LTD benefits.
- ✓ OPFFA members must deplete all accrued sick leave before LTD benefits may become payable.
- ✓ Curbside Waste employees also need to undergo a 17 week waiting period. During this time, if sick leave benefits are not available, employees can apply for Employment Insurance (EI) Sick Benefits.

If your sick leave runs out and you have not received a decision from Great-West Life about your LTD claim, you will be placed on a "LTD pending status" with the City for a period of up to 3 months. Your City of Ottawa employee benefits (health, dental and basic life) will continue to be covered at no cost to you for this period. For additional income, you may:

- Contact your manager to request a **"cash-out"** of your earned vacation leave. The cash-out of your vacation will not reduce your LTD benefits should your claim be approved.

- Apply for **Employment Insurance (EI) Sick Benefits**. A **Record of Employment (ROE)** will be sent to Service Canada by the City's Payroll Branch. Should you have any questions about your ROE, you can call the "payroll information line" at 613 580-2424 ext 28484.

If your absence is related to a recognized **critical illness or an accidental injury** resulting in a loss or use of a limb, sight, speech or hearing, and you have coverage, call Pension and Benefits at **613 580-2424 ext 47411** to discuss your entitlement to a claim. To review the definition of "***Loss"*** please refer to your Benefits Booklet under the Accidental Death and Dismemberment Insurance Plan.

The City's Employee Assistance Program (EAP) offers confidential assistance with any type of problem that can affect your work or personal life including; marital, family, emotional, psychological, work-related problems and addictions. **You can contact the EAP Line at (613) 580-2424 ext. 23816 for more information.** Note: all conversations are confidential except when there is a threat of violence to oneself or others.

If you have any questions, please call the HR service centre at 613 580-2424 ext 47411. You will be provided with the telephone number of the appropriate Disability Management Consultant.

THE
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Disability Income Benefits
Employee Statement Guide

Please use the steps in this guide to help you apply for disability benefits.

Your group plan has a notice of disability claim period. This means you must notify Great-West Life of your disability as early as possible. To notify Great-West Life of your disability, you can fax or mail your employee statement, consent form, and any other information you want to provide about your claim to the Great-West Life Disability Services Office assigned to your claim. Fax numbers and addresses of all Great-West Life Disability Services Offices are on our website or you can contact your plan administrator for this information.

STEP ONE - EMPLOYEE STATEMENT AND CONSENT FORM

Complete the employee statement and consent form if you are applying for either Short or Long Term Disability benefits or Early Referral Services.

The employee statement asks general information about you and your condition and provides Great-West Life with notice of your disability.

A consent form is included with your employee statement. Your signature on the consent form is necessary to give us permission to obtain additional information from your employer, other insurers, your doctor, hospitals, or other care providers to help us review your claim.

STEP TWO - MEDICAL INFORMATION

Your doctor will need to provide us with medical information about how your condition(s) prevents you from working. Print the medical questionnaire form applicable to your condition and have your doctor complete it. Your doctor can fax or mail the completed form to Great-West Life directly.

You can choose the other conditions form if your condition is not a specific diagnosis listed or you can choose the “print all” button if you are unsure which form to bring to your doctor.

EMPLOYER STATEMENT

Your employer will send an Employer Statement to Great-West Life on your behalf. This statement confirms your coverage, job information, monthly earnings and other information necessary to assess your disability claim.

If your plan administrator has not provided the employer statement when we receive your employee statement, we will contact your employer directly for this information.

OUR RESPONSIBILITY

We will review your disability claim when we receive your employee statement in the Disability Management Services Office. At that time, a Great-West Life representative might contact you for more information and let you know what you can expect throughout the claim process.

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Disability Income Benefits Employee Statement

To begin the claim submission process, you must complete the Employee Statement and the consent form. Please have your doctor complete a physician's statement. These forms should be submitted within ten days of the onset of your disability or, if applying for Long Term Disability or a Life Waiver of Premium benefit, no later than eight weeks before the end of the waiting period. **Benefits may be denied if these forms are submitted later than the notice period in your group contract.**

Your Employer's Name: ______________________________

Your Plan Number: ______________________ Your Great-West Life ID Number: ______________________

The information you provide on this form must be true and complete.

YOUR INFORMATION

☐ Mr. ☐ Ms ☐ Mrs. First Name: ______________ Middle Initial: ______ Last Name: ______________

Date of Birth: ______________ Social Insurance Number: ______________

Your Social Insurance Number is required as your disability benefit may be subject to income tax deductions.

Home Address: ______________________________

City / Town: ______________ Province / Territory: ______________ Postal Code: __________

Is your mailing address the same as above? ☐ Yes ☐ No If no, please provide mailing address.

Mailing Address: ______________________________

City / Town: ______________ Province / Territory: ______________ Postal Code: __________

Location where you work: City / Town: ______________ Province / Territory: ______________

Home Phone: ______________ ☐ Confidential

Cell Phone: ______________ ☐ Confidential

Work Phone: ______________ Ext: ______ ☐ Confidential

Check the Confidential box if you wish us to leave a detailed message with personal information about your claim at that number. Otherwise, we will only leave a personal message with callback information at that number.

Email Address: ______________________________

Enter your email address if you would like Great-West Life to communicate with you by secure email about your disability claim.

CLAIM INFORMATION

Your last day of work: ______________ (mm/dd/yy) Your first day unable to work: ______________ (mm/dd/yy)

Have you returned to work? ☐ Yes When did you return to work? ______________

Have you returned to (select all that apply): ☐ Regular duties and hours ☐ Modified duties ☐ Modified hours

☐ No When do you expect to return to work: ______________ **OR** ☐ Unknown **OR** ☐ I'm not planning to return

During your absence, have you performed any other work? ☐ No ☐ Yes

What is the nature of the medical condition preventing you from working?

____

____

____

Is your condition work-related? ☐ No ☐ Yes

Is your condition the result of an accident? ☐ No ☐ Yes

When did the accident occur? ______________ (mm/dd/yy)

How did the accident occur?

____

____

Was the accident a motor vehicle accident? ☐ No ☐ Yes

In what province did your accident occur? ______________

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CLAIM INFORMATION (con't)

Were you admitted to a hospital? ☐ No ☐ Yes

Date admitted: ______________________

Date discharged: ______________________ **OR** ☐ Still hospitalized

Hospital name: ______________________

Have you had surgery since being off work, or is surgery planned? ☐ No ☐ Yes

Date of surgery: ______________ Type of surgery: ______________

Is recovery from your surgery the only medical condition keeping you from working? ☐ No ☐ Yes ☐ Unknown

Please provide the following information of your health care provider related to this claim:

Primary Physician: ______________________ Specialty: ______________

Address: ______________________ Phone Number: ______________

Do you have other health care providers related to this claim? ☐ No ☐ Yes If yes, provide details.

Provider Name: ______________________ Specialty: ______________

Address: ______________________ Phone Number: ______________

Provider Name: ______________________ Specialty: ______________

Address: ______________________ Phone Number: ______________

FINANCIAL INFORMATION

Have you applied for, or are you receiving Canada Pension Plan/Quebec Pension Plan Benefits or Worker's Compensation Board Benefits (or similar plan)?
☐ No ☐ Yes

Have you applied for, or are you receiving any other income? (Examples are automobile insurance, employer sponsored STD or sick leave benefits, Employment Insurance, retirement or pension plan income, self employment or other employment income, etc.) ☐ No ☐ Yes

Describe other income: ______________________

Important: *If your Great-West Life claim is approved, the amount you receive from Canada Pension Plan/Quebec Pension Plan or Worker's Compensation Board may affect your Great-West Life benefit amount. If you are receiving these benefits, attach a copy of the initial benefits statement. You must also notify Great-West Life if you perform any work or receive any other income during your disability claim.*

If you have any of the following coverage with Great-West Life, Canada Life or London Life, please select all that apply:

☐ Individual Disability ☐ Individual Life Insurance ☐ Creditor/Loan Insurance ☐ Critical Illness

Note: *If you have Guaranteed Standard Issue Program coverage with Great-West Life this form will be used as notice of claim for that coverage as well.*

! Provide your banking information or attach a void cheque if you are applying for short or long term disability benefits. Any other benefits you receive under this group plan will be deposited into the same bank account.

Name of bank/credit union: ______________________

Transit number: ☐☐☐☐☐ Institution number: ☐☐☐ Account number: ☐☐☐☐☐☐☐☐☐☐☐☐

⑈000⑈ ⑆01234⑉001 1234 56⑉7⑈

TRANSIT# INSTITUTION# ACCOUNT#

DECLARATION

☐ I declare the information I've entered is accurate. I also acknowledge that I need to print, sign and submit my Consent Form to Great-West Life.

Signature: ______________________ Today's date: ______________

Your consent

Before we can process your claim and pay benefits, you must read this agreement and sign in the *Employee signature* box below.

Sharing your personal information

We collect, use and disclose your personal information so we can:

- investigate and assess your claim
- administer your claim and the group benefits plan
- work out a rehabilitation plan to get you back to work
- audit the assessment of the claim.

We may also use your social insurance number for income tax reporting and as an identification number if this is required in the administration of your benefits.

We may collect and exchange your personal information with these persons or groups when relevant and necessary

- Healthcare and rehabilitation providers
- Insurance and reinsurance companies
- Administrators of the plan, of government benefits and of other benefit programs
- Service providers and other organizations working with us (both inside and outside Canada)
- Your employer, plan sponsor and plan administrator, for the purpose of discussing return to work planning
- Your employer's occupational health services and union representative
- An auditor authorized by us, your employer, plan sponsor or their agent

Protecting your privacy

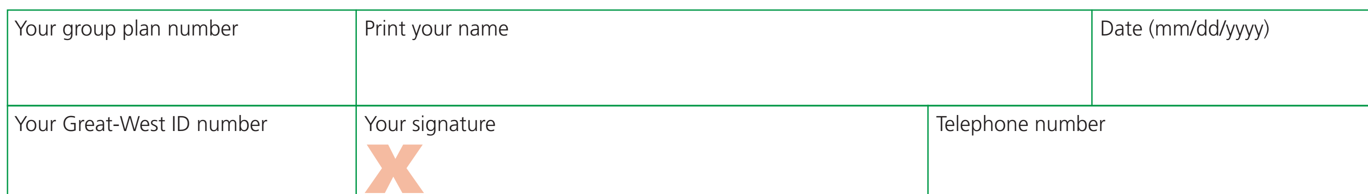
We take your privacy seriously. We keep all your personal information in a confidential file in our offices, or the offices of an organization we've authorized. The only persons with access to the information are those:

- working at Great-West Life and those we've authorized, who need the information to do their jobs and manage your claim
- to whom you've given access
- authorized by law and our service providers, both inside and outside Canada.

For a copy of our Privacy Guidelines see **greatwestlife.com** or you can write to Great-West Life's Chief Compliance Officer.

By signing below, you confirm that:

- You have read, understand and agree with the contents of this form and authorize us to collect and use your personal information
- Except for audit purposes, your authorization is valid for the duration of your claim or until you cancel it in writing.
- All statements you have made about your claim are true and complete
- A photocopy or electronic copy of this authorization is as valid as the original.



Your group plan number	Print your name		Date (mm/dd/yyyy)
Your Great-West ID number	Your signature X	Telephone number	

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INITIAL ATTENDING PHYSICIAN'S STATEMENT

Cancer Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL**.

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. ___________________

Part 1: Patient Authorization

Name (please print): ________________________ Date of birth: Year _________ Month __________ Day ________

Address: Street & Number ____

City ______________________ Province ______________ Postal Code ______________

Telephone Number (including area code): (______) ________________________

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Patient's Signature ______________________________________ Date ______________

Part 2: Attending Physician's Statement

1. **Diagnosis** (including any complications). **Please attach a copy of all consultation, operative and pathology reports.**

   Date of cancer diagnosis: Year __________ Month ______________ Day ________

   Site of the tumor: ____

   Type of tumor: ____

   Histology and staging: ____

2. **History**

   Date symptoms first appeared: Year __________ Month ______________ Day ________

   Has patient ever had the same or similar condition? ☐ Yes ☐ No

   If yes, please specify diagnosis and dates of treatment. ______________________________

   ____

   Describe current symptoms: ____

   First visit for these symptoms: Year __________ Month ______________ Day ________

3. Current Height: ________________ Current Weight: ______________ Weight loss/gain to date: ________________

4. In your opinion, when did the patient's condition first prevent him/her from working?

   Year __________ Month ______________ Day ________

5. **Treatment**

   Date of first visit: Year __________ Month ______________ Day ________

   Date of latest visit: Year __________ Month ______________ Day ________

   Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

   If other, please specify ____

   Treatment: Include information on all treatments to date and future treatment plan, inclusive of:

   Surgery: ____

   Radiation: ____

   Hormones: ____

   Chemotherapy: ____

6. **Hospitalization** (if applicable for this illness or injury)

Date of in-patient admission: Year __________ Month ______________ Day ________

Date of discharge: Year __________ Month ______________ Day ________

Date of out-patient treatment: Year __________ Month ______________ Day ________

Name of hospital: ____

7. Describe response to therapies to date: ☐ N/A ☐ partial ☐ Complete

Describe all comorbid conditions: ____

Describe any "post therapy"sequelae: ____

Prognosis: ____

8. Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

If yes, has your office filed a claim for this condition with the Workers' Compensation Board on behalf of your patient? ☐ Yes ☐ No

9. Please indicate your patient's current physical abilities:

☐ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light Duties: require frequent handling of loads of up to 5 kg, sometimes up to 11 kg, may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

☐ Medium Duties: require frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

☐ Heavy Duties: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

In your opinion, what is the earliest date your patient will be able to return to work?

Year __________ Month ______________ Day ________

If the previous job could be modified, when could rehabilitation employment commence?

Year __________ Month ______________ Day ________

10. Please provide the names of other physicians who have been/will be involved in assessing the medical problems; **and copies of any available consultation reports.**

____

____

11. We would appreciate any additional comments that would help us to better understand your patient and his or her condition.

____

____

____

Name of Physician (please print) ____

Specialty ____

Telephone: ______________________ Fax: ______________________

Email Address: ____

Address (number, street, city, province & postal code):

____

Physician's signature ______________________ Date ______________________

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INITIAL ATTENDING PHYSICIAN'S STATEMENT

Cardiac Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL.**

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. ___________________

Part 1: Patient Authorization

Name (please print): ______________________ Date of birth: Year ________ Month ________ Day ________

Address: Street & Number ______________________________

City ______________________ Province ____________ Postal Code ____________

Telephone Number (including area code): (______) ______________________

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Patient's Signature ______________________________ Date ______________

Part 2: Attending Physician's Statement

1. **Diagnosis** (please provide copies of all relevant clinical notes, test results and consultation reports on file)

Primary: ______________________________

Secondary: ______________________________

Date symptoms first appeared Year ________ Month ________ Day ________

Date of first visit Year ________ Month ________ Day ________

Date patient's condition first prevented them from working: Year ________ Month ________ Day ________

Date of latest visit: Year ________ Month ________ Day ________

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ______________________

Date of hospital inpatient admission: Year ________ Month ________ Day ________

Date of discharge: Year ________ Month ________ Day ________

Date of hospital outpatient admission: Year ________ Month ________ Day ________

Name of hospital: ______________________________

Subjective symptoms (including severity/frequency/duration): ______________________________

2. **Findings**

☐ Chest pain of cardiac origin ☐ Syncope ☐ Fatigue ☐ Dyspnea due to vascular congestion or hypoxia

☐ Psychophysiologic ☐ Other (please specify): ______________________________

BP readings over last 6 months (including dates) ______________________________

Current height ____________ Current weight ____________ Weight loss/gain to date ____________

Current status? ☐ Stable ☐ Improving ☐ Regressing

3. **Laboratory tests** (completed/scheduled) - please include copies of relevant test results.

EKG	Year ___________	Month ______________	Day ________
Echocardiogram	Year ___________	Month ______________	Day ________
Stress Thallium Test	Year ___________	Month ______________	Day ________
Pulmonary Function Test	Year ___________	Month ______________	Day ________
Blood Test	Year ___________	Month ______________	Day ________
X-rays	Year ___________	Month ______________	Day ________
Angiogram	Year ___________	Month ______________	Day ________

4. **Treatment**

Medications (dose / frequency / date prescribed): ______________________________

Other treatment (please describe): ______________________________

Surgery date (past): Year ___________ Month ______________ Day ________ Type: ______________________

Surgery date (future): Year ___________ Month ______________ Day ________ Type: ______________________

Other treating physicians: ______________________________

Is patient compliant with prescribed treatment? ☐ Yes ☐ No If No, please explain: ______________________

____

Has your patient been enrolled in a cardiac rehab program? ☐ Yes ☐ No

If yes, provide details: ______________________________

____

5. **Restrictions and limitations**

Functional capacity: (Canadian Cardio-Vascular Society (CCS))

☐ Level 1 (no limitation) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

	Weight	Frequency	Duration	What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation?
Lifting/Carrying	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			
Pushing/Pulling	1-10 lbs (0.5-4.5 kg) 11-20 lbs (5.0-9.1 kg) 21-50 lbs (9.5-22.7 kg)			How does this affect the patient's ability to perform activities of daily living?
Standing __________ hours Walking __________ blocks Driver's license revoked? ☐ Yes ☐ No				

6. **Return to work plans:**

Prognosis for recovery: ______________________________

Expected date patient will return to their own occupation: Year ___________ Month ______________ Day ________

If unknown, please indicate the next follow up date: Year ___________ Month ______________ Day ________

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work) ______________________________

Assessment and treatment are complicated by: (please select and explain in the space provided below)

☐ Significant emotional or behavioral disorder such as depression, anxiety, etc.

☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

☐ Work-related issues (please describe if known) ____________________

☐ Substance abuse ____________________

☐ Other (please describe) ____________________

____

Rehabilitation:

Is patient a suitable candidate for medical rehabilitation services (ie. cardiopulmonary program, speech therapy, etc.)?

☐ Yes ☐ No

Is patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No

If yes to either of the above, please specify: ____________________

7. **Comments**

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

____

____

____

____

Name of Physician (please print) ____________________

Specialty ____________________

Telephone: ____________________ Fax: ____________________

Email Address: ____________________

Address (number, street, city, province & postal code):

____

Physician's signature ____________________ Date ____________________

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Mental Health Conditions

Attending Physician's Statement

Section A	Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Group Plan Number	GWL Employee Identification Number	Date of Birth (dd/mm/yyyy)

Date Last Worked (dd/mm/yyyy) ________	**Date Returned to Work or Expected Return to Work Date, if known** (dd/mm/yyyy) ________	**Please provide your:** Height: ____ Weight: ____

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I understand that I am responsible for any fees related to the completion of this form.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

________________________ Plan Member/Employee Signature

________________________ Date of Consent (dd/mm/yyyy)

Section B	Attending Physician's Questionnaire TO BE COMPLETED BY THE DOCTOR

I am the: Attending Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) ________________

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. Diagnosis

Primary: ____

____

Secondary: ____

____

Is this condition related to: Occupational Illness/injury ☐ Auto accident ☐ If so, date of event: (dd/mm/yyyy) ________

Details: ____

____

____

Date of first visit to you pertaining to this condition (dd/mm/yyyy) ________	First date of work absence due to this condition: (dd/mm/yyyy) ________

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (dd/mm/yyyy) ________ By whom: ________

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.)

____

The Great-West Life Assurance Company

CLHIA ACCAP

2. Patient's Description of Symptoms

Please describe the patient's current symptoms including frequency and severity: ______

______

______

______

______

3. Your Clinical Findings and Observations

Please describe how the condition has impacted the following and to what degree:

	No impact	Mild	Moderate	Severe
Appearance	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Energy / Vigour	☐	☐	☐	☐
Behaviour	☐	☐	☐	☐
Decision Making	☐	☐	☐	☐
Socialization	☐	☐	☐	☐
Concentration / Focus	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Affect / Mood	☐	☐	☐	☐
Insight / Judgment	☐	☐	☐	☐
Self-Criticism	☐	☐	☐	☐

Observations or comments supporting the above: ______

______

______

4. Complicating Factors

Please indicate all factors that may have contributed to the clinical problem(s) and may complicate the patient's recovery period:

☐ Workplace Issues ☐ Social / Family Issues ☐ Financial / Legal Problems

☐ Physical Condition ☐ Alcohol / Drug Abuse ☐ Medication Side Effects

☐ Pain Perception ☐ Coping Skills ☐ Personality / Motivation ☐ Other

Please describe:

______

______

______

______

Please describe the supports in place, or planned, to assist with these issues:

______

______

______

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5. Investigations

Please attach copies of all relevant:
- test results/investigations (if test results are not attached, we will interpret this as tests were not performed)
- consultation reports

Are tests / investigations / consultations pending? Yes ☐ No ☐ Date report expected: (dd/mm/yyyy) ____________

Does the patient have an appointment booked with an specialist(s) in the near future? Yes ☐ No ☐

	Name of Specialist	Specialty	Date of Appointment: (dd/mm/yyyy)
1.			
2.			

Reason for requesting the consultation: ____________

Has any license held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐ Don't know ☐

If yes, as of when? (dd/mm/yyyy) ____________ Type of licence: ____________

6. Medications (please attach separate list if insufficient space)

Medication Name	Initial dosage and date started (dd/mm/yyyy)	Current dosage and date changed if applicable (dd/mm/yyyy)	Response

7. Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization anticipated? Yes ☐ No ☐

	Date admitted (dd/mm/yyyy)	Date discharged (dd/mm/yyyy)	Institution Name
1.			
2.			

8. Treatment Details - Psychological (e.g.: cognitive behavioural, drug/alcohol, group, family, marital, Day Hospital program)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

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9. Treatment Details - Concurrent Physiological Disorders, if known (e.g.: physiotherapy, chiropractic, other rehabilitation therapy)

Type of therapy	Name of provider or facility	Date treatment began (dd/mm/yyyy)	Frequency of visits	Date of last visit (dd/mm/yyyy)	Response
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		
			Wkly ☐ Mthly ☐ Other ☐		

10. Overall Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please explain: ______________________________

____

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: ______________________________

____

11. Prognosis and Recovery

What return-to-work goals have been discussed with the patient? Please explain: ______________________________

____

____

Please provide the patient's prognosis for improvement: ______________________________

Please provide any other information that will help us understand the patient's current condition recovery goals and prognosis:

____

____

____

____

Notice to Physician

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law.

Attending Physician (please print)	Physician's Specialty	Date Signed (dd/mm/yyyy)
Address		Telephone # (+ Area Code)
Email Address		Fax # (+ Area Code)
Signature or Stamp		

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INITIAL ATTENDING PHYSICIAN'S STATEMENT

Musculo-skeletal Form

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM, PLEASE ANSWER **ALL** OF THE QUESTIONS IN **FULL.**

Instructions:

1. Please **PRINT**.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completion of this form is the patient's responsibility.

PLAN NO. ____________________

Part 1: Patient Authorization

Name (please print): ______________________________ Date of birth: Year ________ Month __________ Day ________

Address: Street & Number ____

City ______________________________ Province ______________ Postal Code ________________

Telephone Number (including area code): (______) ________________________________

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

Patient's Signature ____ Date ____________________

Part 2: Attending Physician's Statement

1. **Diagnosis (please provide copies of all relevant clinical notes, test results and consultation reports)**

Primary: ____

Secondary: ____

Date symptoms first appeared Year __________ Month ____________ Day ________

Date patient's condition first prevented them from working Year __________ Month ____________ Day ________

Date of first visit for treatment or consultation Year __________ Month ____________ Day ________

Has patient ever had the same or a similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe: ____

Is condition a result of an injury due to an accident? ☐ Yes ☐ No

If yes, please describe. ____

Current height ______________ Current weight ______________ Weight loss / gain to date ______________

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

If yes, have Workers' Compensation Board/CSST forms been completed? ☐ Yes ☐ No

Date of latest visit: Year __________ Month ____________ Day ________

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ____

Date of hospital inpatient admission: Year __________ Month ____________ Day ________

Date of discharge: Year __________ Month ____________ Day ________

Date of hospital outpatient admission: Year __________ Month ____________ Day ________

Name of hospital: ____

Other treating physicians: ____

Pending referrals to specialists: ____

2. Please outline all objective studies performed / scheduled (X-rays, laboratory data, C.T. scans, etc.) and **attach copies of each report.**

Date	Procedure	Results

3. Please indicate the nature and severity of the patient's symptoms and signs.

	Please specify location(s) and physical findings	Severe	Moderate	Mild	Absent
Pain		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle Spasm		☐	☐	☐	☐
Muscle Atrophy		☐	☐	☐	☐
Loss of Tendon Reflexes		☐	☐	☐	☐
Sensory Change		☐	☐	☐	☐
Motor Deficit		☐	☐	☐	☐
Straight Leg Raising Limitation		☐	☐	☐	☐
Range of Motion Limitation		☐	☐	☐	☐
Other (specify)		☐	☐	☐	☐

If Arthritic Condition: ☐ In Remission ☐ Continuously Active ☐ Stable ☐ Seasonally Active ☐ Intermittently Active ☐ Progressive

If Fracture: ☐ Closed ☐ Depressed ☐ Open ☐ Compressed ☐ Comminuted

4. **Treatment**

Medications (dose / frequency / date prescribed): ____________________

Physiotherapy (type, frequency, dates): ____________________

Surgery date (past): Year ________ Month ________ Day ________ Type: ____________

Surgery date (future): Year ________ Month ________ Day ________ Type: ____________

Other treatment: ____________________

Is patient compliant with prescribed measures? ☐ Yes ☐ No If No, please explain: ____________

5. **Limitations and Restrictions**

		Hours at one time					Total hours during day				
		<1	1-2	2-4	4-6	6-8	<1	1-2	2-4	4-6	6-8
Stand	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk on uneven surfaces	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
This patient can lift/carry a maximum of:	kgs	0	5	9	14	18	23	27	32	36	41+
	lbs	0	10	20	30	40	50	60	70	80	90+
☐ No restriction	☐ Repetitively - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally - how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please indicate in the space provided if this patient is able to perform the following actions:
(Frequently (F), Occasionally (O) or Not at all (N):)

Drive ____ Bend ____ Squat ____ Kneel ____ Climb ____ Reach (above shoulders) ____ Reach (below shoulders) ____

6. **Prognosis / Return to work plans:**

Prognosis for recovery: ____________________

Expected date patient will return to their own occupation: Year ________ Month __________ Day ______

If unknown, please indicate the next follow up date: Year ________ Month __________ Day ______

If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work). ____________________

____

Assessment and treatment are complicated by: (please select and explain in the space provided below)

☐ Significant emotional or behavioral disorder such as depression, anxiety, etc.

☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

☐ Work-related issues (please describe if known) ____________________

☐ Substance abuse ____________________

☐ Other (please describe) ____________________

____

Rehabilitation:

Is patient a suitable candidate for medical rehabilitation services? ☐ Yes ☐ No

Is patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No

If yes to either of the above, please specify: ____________________

____

7. **Comments**

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

____

____

____

____

Name of Physician (please print) ____________________

Specialty ____________________

Telephone: ____________________ Fax: ____________________

Email Address: ____________________

Address (number, street, city, province & postal code):

____

Physician's signature ____________________ Date ____________________

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The patient is responsible for any fees related to the completion of this form.

Other Conditions

Attending Physician's Statement - Long Term Disability Claim

Section 1	Plan Member/Employee Information and Consent TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Group Plan Number	GWL Employee Identification Number	Date of Birth (dd/mm/yyyy)

Date Last Worked (dd/mm/yyyy)	**Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy)

Please list your present medications:

	Name of Medication	Dosage (mg)	How Often?
1.			
2.			
3.			
4.			
5.			

Please provide your:

Height: ____________

Weight: ____________

Dominant Hand:

Left ☐ Right ☐

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

______________________________ Plan Member/Employee Signature

______________________________ Date of Consent (dd/mm/yyyy)

Section 2	Attending Physician's Statement TO BE COMPLETED BY THE DOCTOR

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) ______________________

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Diagnosis

Primary: ______________________________

Secondary and/or Complications: ______________________________

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy) ______________________________

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Is this condition due to:

Occupational Illness/injury Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) ____________

Auto Accident Yes ☐ No ☐

If yes, date of event: (dd/mm/yyyy) ____________

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor: (other insurance company, CPP, QPP, Workers Compensation Board, etc.) ____________

Date of first visit to you pertaining to this condition:

(dd/mm/yyyy) ____________

First date of work absence due to condition:

(dd/mm/yyyy) ____________

Treatment

e.g. Special Programs, Therapies, Medications: (if not noted by patient in **Section 1**)

____

____

____

____

Frequency of Visits: Weekly ☐ Monthly ☐ Other ☐ (describe) ____________

Date of last visit: (dd/mm/yyyy) ____________

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date: (dd/mm/yyyy) ____________ Treatment provider: ____________

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate: ____________

Response to Treatment

Please describe the response to treatment to date: Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain: ____________

Hospitalization

Is/was the patient hospitalized? Yes ☐ No ☐ Is future hospitalization planned? Yes ☐ No ☐

	Date of admittance (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Institution Name
1.			
2.			
3.			

If surgery was/will be performed, please provide date(s) and description of surgery(s):

	Date (dd/mm/yyyy)	Description
1.		
2.		

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Investigations

➡ **Please attach copies of all relevant:**
- **test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

Are tests/investigations pending? Yes ☐ No ☐

	Date (dd/mm/yyyy)	Description
1.		
2.		

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (dd/mm/yyyy)
1.			
2.			

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity and frequency:

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Functional Abilities

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical functional abilities:

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Has any licence held by the patient been restricted or revoked as a result of this condition? Yes ☐ No ☐

If yes, as of when? (dd/mm/yyyy) ______________________ Type of licence: ______________________

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals?

Yes ☐ No ☐ Please elaborate:

____

____

____

____

____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery:

____

____

____

Return-to-Work

What return-to-work goals have been discussed with the patient? Please elaborate:

____

____

____

____

____

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ Area Code)	Fax # (+ Area Code)	
Email Address		
Signature	Date Signed (dd/mm/yyyy)	

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